DIOCESE *of* LA CROSSE

EMPLOYEE MEDICAL BENEFIT PLAN GUIDE - Lay Group

Plan Year 2024

ST. AMBROSE
FINANCIAL SERVICES, INC.

OVERVIEW

- **Plan Year**
  - January 1 – December 31, 2024
- **Premiums**
  - Health Plans
    - Traditional increase of 5%
    - HDHP/HSA increase of 5%
  - Dental Plan increase of 5%
- **Primary Medical Networks**

  Anthem
  - www.anthem.com/contact-us/wisconsin/
  - **833.952.2061**
- **Prescription Drug / Pharmacy Benefit**
  - CVS caremark
  - www.caremark.com/
  - **800-565-7091**
- **VSP Vision Plan**
  - vsp vision care Coverage included if enrolled in Health Plan
  - Can be added as a separate benefit if not enrolled in a Health Plan
  - Member Services - - **800-877-7195** or www.vsp.com
- **Delta Dental Plan**

  DELTA DENTAL
  - https://www.deltadentalwi.com/DDWI/s/

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BENEFIT ELIGIBILITY

Eligible Employee:

- Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).
- Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours)
- A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours)

Additional family members eligible:

- Spouse
- Children, including stepchildren and children placed for adoption with the covered employee, who are up to 26 years old, regardless of student or marital status
- Dependent Children of any age who are disabled or incapable of self support due to physical or mental disability

PLEASE NOTE: If you and your spouse are employed within the Diocese of La Crosse and are eligible for the **Diocese of La Crosse Lay Group Employee Medical Benefit Plan**, you can be covered as an employee or as a dependent, but not both. Only one of you can cover your dependents.

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BENEFIT ELIGIBILITY

Anthem

DIOCESE OF LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

SAFS Admin Use Only - Effective Date:

PARISH/INSTITUTION _____ City _____ # ____ Group # 106588

EMPLOYEE INFO
Last Name | First Name | MI | Birth Date | Social Security Number
Street Address | City | State | Zip | Personal Email | Phone Number
☐ Single ☐ Female ☐ Married ☐ Male | Job Title | First Date of Work / First Date of Eligibility | Hours / Week

PURPOSE OF FORM (Must mark one box):
☐ NEW EMPLOYEE (Eligible the first of the month, following First Date of Work)
☐ OPEN ENROLLMENT (Specific period of time to enroll or make changes)
☐ CHANGE
- ☐ Termination / Resignation / Retirement / Reduction of Hours to ____ Hours / Week Last Day of Work / Eligibility ____
- ☐ Address – provide new address under employee info
- ☐ Name Change New Name _____ Former Name _____
- ☐ Other - personal email, phone number, job title
- ☐ Dependent(s)
  - ☐ Add ☐ Delete Name _____ Birth Date ____ SS# ____ Relation ____
  - ☐ Add ☐ Delete Name _____ Birth Date ____ SS# ____ Relation ____
- ☐ Qualifying Event _____
  State the Qualifying Date and the Qualifying Event -- (Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)

MEDICAL / VISION / DENTAL ELECTION - Select elections you are keeping or the elections you are changing to/or select WAIVE

Medical: ☐ Employee ☐ Family ☐ WAIVE
Plan & Deductible: ☐ Traditional Deductible ☐ High Deductible/HSA
Vision (Included w/Medical if Enrolled): ☐ Employee ☐ Family ☐ WAIVE
Dental: ☐ Employee ☐ Employee & 1 dependent ☐ Family ☐ WAIVE

OTHER INSURANCE COVERAGE As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? ☐ No ☐ Yes
If Yes, Primary Insured Name _____ Carrier _____ Group/Policy # _____ Effective Date _____
Dependents Covered _____ Medical ☐ Employee ☐ Family Vision ☐ Employee ☐ Family Dental ☐ Employee ☐ Family

LIFE INSURANCE ELECTION
BASIC LIFE / AD&D ☐ $30,000 ☐ WAIVE *If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.*
Primary Beneficiary _____ Relationship _____
Contingent Beneficiary _____ Relationship _____

Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.
As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.
Spouse Signature _____ Date _____

DEPENDENT INFORMATION (List all dependents to be covered under this plan)*:

	Name (Last, First, Middle Initial)	Sex (M/F)	Birth Date	Social Security Number
Spouse				
Child				
Child				
Child				
Child				

*(Additional dependents, please list on next page

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION
I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.
I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event.
I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

Employee Signature (Required) _____ *Date* _____

See Reverse Side for Additional Important Information

ST. AMBROSE FINANCIAL SERVICES, INC. P.O. Box 4004 La Crosse, WI 54602-4004 Phone: (608) 791-2669 Fax: (608) 787-8068 https://www.stambrosefinancial.com Revised 01/2023

To Enroll

The decisions you make at this time can impact your life and finances. It is important to take the time to review and evaluate your options, then complete the **Enrollment - Change Form**.

When To Enroll

- Open Enrollment – Nov. 27 – Dec. 14, 2023
- New employees – complete the **Enrollment Form** within 31 days of the employee's first day of work.

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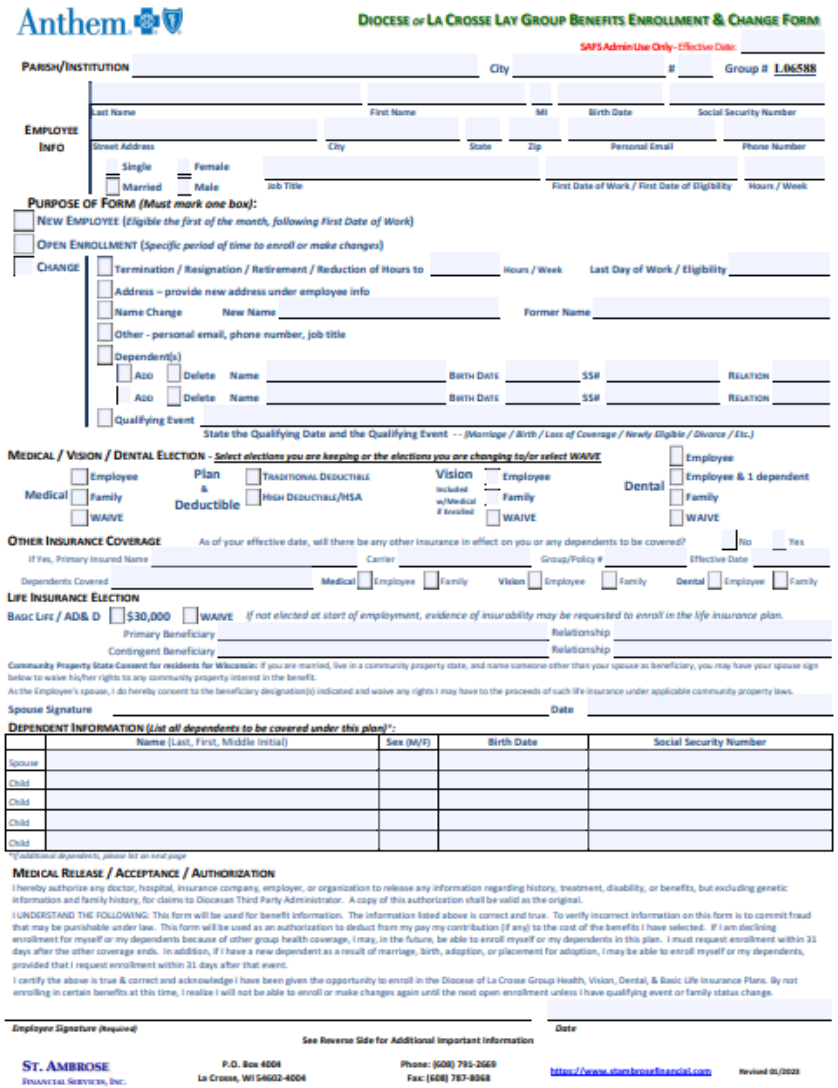
BENEFIT ELIGIBILITY



Anthem

DIOCESE OF LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

SAFS Admin Use Only - Effective Date:

PARISH/INSTITUTION City # Group # L06588

EMPLOYEE INFO
Last Name First Name MI Birth Date Social Security Number
Street Address City State Zip Personal Email Phone Number
Single Female Married Male Job Title First Date of Work / First Date of Eligibility Hours / Week

PURPOSE OF FORM (Must mark one box):
NEW EMPLOYEE (Eligible the first of the month, following First Date of Work)
OPEN ENROLLMENT (Specific period of time to enroll or make changes)
CHANGE
Termination / Resignation / Retirement / Reduction of Hours to Hours / Week Last Day of Work / Eligibility
Address – provide new address under employee info
Name Change New Name Former Name
Other - personal email, phone number, job title
Dependent(s)
Add Delete Name Birth Date SS# Relation
Add Delete Name Birth Date SS# Relation
Qualifying Event
State the Qualifying Date and the Qualifying Event -- (Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)

MEDICAL / VISION / DENTAL ELECTION - Select elections you are keeping or the elections you are changing to/or select WAIVE
Medical: Employee, Family, WAIVE
Plan & Deductible: Traditional Deductible, High Deductible/HSA
Vision (Included w/Medical if Enrolled): Employee, Family, WAIVE
Dental: Employee, Employee & 1 dependent, Family, WAIVE

OTHER INSURANCE COVERAGE As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? No Yes
If Yes, Primary Insured Name Carrier Group/Policy # Effective Date
Dependents Covered Medical Employee Family Vision Employee Family Dental Employee Family

LIFE INSURANCE ELECTION
BASIC LIFE / AD& D $30,000 WAIVE If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.
Primary Beneficiary Relationship
Contingent Beneficiary Relationship
Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.
As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.
Spouse Signature Date

DEPENDENT INFORMATION (List all dependents to be covered under this plan)*:

	Name (Last, First, Middle Initial)	Sex (M/F)	Birth Date	Social Security Number
Spouse				
Child				
Child				
Child				
Child				

*If additional dependents, please list on next page

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION
I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.
I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event.
I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

Employee Signature (Required) Date

See Reverse Side for Additional Important Information

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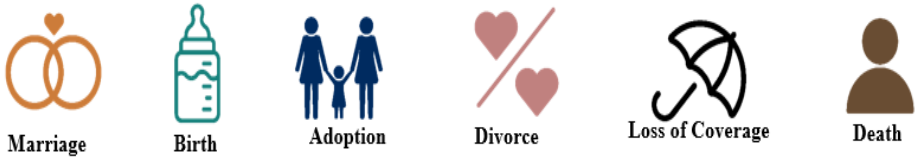
How To Make Changes

- Unless you experience a Qualifying Event, changes to the plan cannot be made until the next open enrollment. If you experience a qualifying event, you have 31 days from the date of the event to make benefit changes. Changes are made via the **Enrollment - Change Form.**
- Qualifying events include:
  - Change with child's dependent status
  - Employment change
  - Change in coverage or eligibility under another plan



The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse Lay Group Employee Medical Benefit Plan and is not intended to be all inclusive. For more information, visit **www.StAmbroseFinancial.com – Health Plan - Lay Group**.

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COVERAGE

Benefits become effective:

- **Open Enrollment**
  - Effective beginning of plan year – January 1, 2024
- **New Employee**
  - First day of the month following the first day of employment
- **Qualifying Event**
  - Either the first day of the event or the first day of the month following the qualifying event, depending on termination date of coverage previously provided
- **Terminated employees**
  - May continue coverage on a self pay basis as outlined in the ***Continuation of Coverage*** section of the Summary of Plan Description

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HIGH DEDUCTIBLE HEALTH PLAN / HSA

Benefit	PPO	Non-PPO
Deductible	Employee - $2,200 Family - $3,200 per individual $4,200 per family	Employee - $2,200 Family - $3,200 per individual $4,200 per family
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
Maximum Out of Pocket	Employee - $3,200 Family - $6,200	Employee - $5,200 Family - $10,200
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Insured pays 20% after deductible to Maximum Out-of-Pocket	Insured pays 30% after deductible to Maximum Out-of-Pocket
	Insured pays full discounted price.	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

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High Deductible Health Plan / HSA

Premiums 2024

Monthly premium effective January 1, 2024

Vision coverage included if enrolled in Health Plan

	Premium Rates High Deductible / HSA Eligible Plan
Employee	$ 975 / month
Family	$ 2,480/ month

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TRADITIONAL DEDUCTIBLE HEALTH PLAN

Benefit	PPO	Non-PPO
Deductible	Employee - $1,000 Family - $2,000	Employee - $1,000 Family - $2,000
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
Maximum Out of Pocket	Employee - $2,000 Family - $4,000	Employee - $4,000 Family - $8,000
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Retail - 70% Insurance / 30% Insured to maximum out of pocket of $1,000 per individual & $3,000 per family	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

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Traditional Deductible Health Plan

Premiums 2024

Monthly premium effective January 1, 2024

Vision coverage included if enrolled in Health Plan

	Premium Rates Traditional Plan Deductible
Employee	$ 1,406 / month
Family	$ 3,573 / month

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Financial Services, Inc.

PRESCRIPTIONS (PHARMACY BENEFIT)

Provider – **CVS caremark**

Listed on the Medical ID card which is presented when purchasing prescription drugs at participating pharmacies in your area. The Pharmacy Benefit is as follows:

- **Traditional Health Plan**
  - Retail purchases at a pharmacy for generic prescriptions - 30% copayment of the total drug cost, with a minimum payment of $10 per prescription, or actual total cost if less than $10.
  - Brand name prescriptions - 30% copayment of the total drug cost.
  - Prescription drug copayments are not applied to the plan deductible or coinsurance
  - Maximum out of pocket of $1,000 per person, up to $3,000 per family, each plan year for copays
- **HDHP/HSA Plan**
  - Prescription drug copayments are applied to the plan deductible or coinsurance.
- **Mail Order option**
  - Approximately 80% of the prescription drugs currently used are maintenance drugs and typically can be purchased via the mail order option - saves time and money.
- Check with provider to see if a generic equivalent is available for brand name/non-generic drugs.

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DENTAL PLAN

COVERAGE SUMMARY – Delta Dental

Deductible	Employee - Deductible = $0 Employee + 1 dependent = $0	$1,500 - Maximum Benefit per participant per plan year	
	Family - Deductible = $0	$ 3,000 - Maximum Benefit per plan year	
Diagnostic & Preventative	Examinations, Bitewing X-rays, Teeth Cleaning **2 times per benefit year**		100%
Preventive Charges			100%
Basic Dental	• Extractions & other oral surgery • Restorations - amalgam, composite (front teeth), stainless steel prefabricated crowns (1 per tooth in a 3-year period) • Endodontics (root canal treatment & therapy) • Periodontics (treatment of gum) • Repairs/adjustments to prosthetic appliances & Dentures • Anesthesia and Injections • Emergency Palliative Treatment		80%
Major Dental	• Crowns, inlays or onlays • Prosthetics - fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth • Porcelain veneers on crowns on the six front teeth, bicuspids and upper first molars.		50%

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DENTAL PLAN
PREMIUMS 2024

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

PREMIUM RATES	
Employee Only	$ 39
Employee plus 1	$ 76
Employee plus 2 or more (Family)	$ 126

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VISION PLAN

vsp

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME[†]	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart/Sam's Club frame allowance • $110 Costco frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE[™†]	• $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$25	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on Featured Frame Brands. Go to **vsp.com/offers** for details. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		
YOUR COVERAGE GOES FURTHER IN-NETWORK			
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.			

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VISION PLAN
PREMIUMS 2024

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

PREMIUM RATES	
Employee Only	$ 4.95
Family	$ 11.82

NOTE:

- The Vision Insurance premium is included at no added cost for employees enrolled in the Diocese of La Crosse Lay Group Employee Health Plan
- Family Vision is available as a stand-alone benefit. You can elect Employee Only Health and Family Vision, or you can elect Vision without any Health benefit.

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PREMIUMS 2024

SUMMARY

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2024

HDHP / HSA (VISION COVERAGE INCLUDED IN PLAN)	
Employee	$ 975
Family	$ 2,480

TRADITIONAL (VISION COVERAGE INCLUDED IN PLAN)	
Employee	$ 1,406
Family	$ 3,573

DENTAL	
Employee	$ 39
Employee plus 1	$ 76
Family	$ 126

VISION (VOLUNTARY)	
Employee	$ 4.95
Family	$ 11.82

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BASIC LIFE

Group Life	
Eligibility	• Enrollment must take place within 31 days following the first day of work with employer within the Diocese of La Crosse • Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours) • A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours) • All other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours) • Late Enrollees must complete Evidence of Insurability and are subject to approval. Coverage is effective upon approval.
Death Benefit	$30,000
Accidental Death and Dismemberment Benefit	$30,000

Basic Life monthly premium - $3.90 per month, typically paid by the employer.

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VOLUNTARY LIFE

Eligibility	Employees who work at least 20 hours per week
Benefits	Life insurance in $10,000 increments up to $500,000 (not to exceed 5 times annual income). Non-medical maximum of $150,000. If coverage is selected, employee can choose coverage for spouse and/or dependent child(ren) up to age 18 (23 if a full-time student). Coverage for spouses is in $5,000 increments up to $100,000 (not to exceed 50% of the employee election), non-medical maximum of $25,000. Coverage for dependent child(ren) is in increments of $2,500, $5,000, $7,500, or $10,000, without medical underwriting.
Costs	Monthly premium charges depend on age and benefit amount elected. Premiums are paid by the employee.
Can I be turned down?	If enrolled when first eligible, employee and dependents can be covered for up to the non-medical (guarantee issue) maximum listed without medical questions, provided the eligibility requirements listed above are met.
When Can I Enroll?	Enrollment must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will be required to wait until the next annual enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

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VOLUNTARY LONG-TERM DISABILITY

Eligibility	Employees who work at least 20 hours per week
Benefits	You can receive up to 60% of your gross income if you become disabled due to a sickness or injury, on or off the job. Benefits begin after 90 days of disability and can last until age 65 or beyond.
Costs	Monthly premium charges vary depending on your age and income. Premiums are paid entirely by the employee. You will receive a summary of benefits with information on rates and how to calculate monthly premiums.
Can I be turned down?	If you enroll when first eligible, you cannot be turned down regardless of your health, as long as you meet the eligibility requirements listed above.
When Can I Enroll?	Enrollment for the voluntary long term disability insurance must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will need to wait until the next open enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

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RESOURCES

ST. AMBROSE
FINANCIAL SERVICES, INC.

www.stambrosefinancial.com

Email: SAFS@stambrosefinancial.com
Phone #: **608.791.2669**
Fax #: **608.787.8068**

Dennis Herricks - Executive Director
EXTENSION 1 / dherricks@stambrosefinancial.com

Angela Domenget - Benefits Manager
EXTENSION 3 / ccummings@stambrosefinancial.com

Rachel Melde - Benefits Assistant
EXTENSION 4 / rmelde@stambrosefinancial.com